Appendix A. The Methamphetamine Treatment Project

Overview

Conducted over 18 months between 1999 and 2001, the Methamphetamine Treatment Project (MTP) is (to date) the largest randomized clinical trial of treatment approaches for methamphetamine dependence; 978 individuals participated in the study (Rawson et al. 2004). MTP researchers randomly assigned participants at each treatment site into either the Matrix model treatment or the program's treatment as usual (TAU). The study design did not standardize TAU across sites, so each program offered different outpatient treatment models (including lengths of treatment ranging from 4 to 16 weeks). All TAU models, along with the Matrix model, either required or recommended that participants attend 12-Step or mutual-help groups during their treatment, and all treatment models encouraged participation in continuing care activities after primary treatment.

The characteristics of a cross-section of participants in MTP (both TAU and Matrix participants) were found to be consistent with those of the clinical populations who participated in similar studies of treatment for methamphetamine abuse (Huber et al. 1997; Rawson et al. 2000). Figure A-1 lists specific client characteristics.

Figure A-1. Characteristics of MTP Participants

Male Female	45% 55%	Average education	12.2 years
Caucasian Hispanic/Latino Asian/Pacific Islander Other*	60% 18% 17% 5%	Employed	69%
Average age	32.8 years	Average lifetime methamphetamine use Average days of methamphetamine use in the past 30 days	7.54 years 11.53 days
Married and not separated	16%	Preferred route of methamphetamine administration Smoking Intravenous Intranasal	 65% 24% 11%

**Two percent of participants in the Other category were African American (personal correspondence with Jeanne Obert, Matrix Institute, November 2004).*

Source: Rawson et al. 2004, p. 711.

Participants' histories indicated multiple substance use. During the study, participant self-reports and drug and breath-alcohol tests confirmed that some clients had used marijuana or alcohol, as well as methamphetamines, but no other substances of abuse were identified.

All MTP participants completed baseline assessments including the methamphetamine-dependence checklist in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association 1994), and the Addiction Severity Index (McLellan et al. 1992). The assessments were repeated at several points during participants' active treatment, at discharge from treatment, and at 6 and 12 months after their dates of discharge from the program. Urine drug testing was conducted weekly throughout active treatment.

Results

No significant differences in substance use and functioning were found between TAU and Matrix groups at discharge and at 6-month followup. However, the MTP study found that the Matrix model participants (Rawson et al. 2004)

- Had consistently better treatment retention rates than did TAU participants
- Were 27 percent more likely than TAU participants to complete treatment
- Were 31 percent more likely than TAU participants to have methamphetamine-free urine test results while in treatment

At 6-month followup, more than 65 percent of both Matrix and TAU participants had negative urine tests for methamphetamine and other drugs (Rawson et al. 2004).

Appendix B.
Notes on Group Facilitation

All clients in a group develop individual relationships with their counselor. The degree to which the counselor can instigate positive change in clients' lives is related directly to the credibility that the counselor establishes. The counselor must be perceived as a highly credible source of information about substance use. Two keys to establishing credibility with clients are the degree to which the counselor engages and maintains control over a group and the counselor's ability to make all participants perceive the group as a safe place.

These two elements are highly interrelated. For a group to feel safe, the members need to view the counselor as competent and in control. Sometimes, group members enter the group with a lot of energy and are talkative and boisterous. Frequently this situation occurs during holidays, particularly if several members have relapsed. The counselor should use verbal and nonverbal methods of calming the group and focusing the group on the session topic. Conversely, there may be times when group members are lethargic, sluggish, and depressed. During these times, the counselor should infuse energy and enthusiasm. He or she needs to be aware of the emotional tone of the group and respond accordingly.

In a similar manner, the members of a group need to feel that the counselor is keeping the group moving in a useful and healthful direction. The counselor must be willing to interrupt private conversations in the group, terminate a graphic drug use story, or redirect a lengthy tangential diversion. He or she must be perceived as clearly in control of the time in the group. Each member must be given an opportunity to have input. The counselor should ensure that a few members do not monopolize the group's time. Clients must feel that the counselor is interested in their participation in the group as it relates to abstinence. The counselor must be clearly, actively, unquestionably in control of the group.

The counselor needs to be sensitive to emotional and practical issues that arise in group. At times it also may be necessary to be directive and confrontational or to characterize input from group members as a reflection of addictive thinking. In these instances the counselor should focus on the addiction as opposed to the person. In other words, care should be taken to avoid directing negative feedback toward the client, focusing instead on the addiction-based aspects of the client's behavior or thinking.

The counselor is preferably the professional who also sees the members of the group for the prescribed Individual/Conjoint sessions. The advantage of this dual role (group leader and individual counselor) is that the counselor can coordinate more effectively and guide the progressive recovery of each individual. The frequency of contact also strengthens the therapeutic bond that can hold the client in treatment. A potential disadvantage of the dual role is the possible danger that the counselor may inadvertently expose confidential client information to the group before the client chooses to do so. It is a violation of boundaries for the counselor even to imply that information exists and to attempt to coerce a client into sharing that information if the client has not planned to do so in the group.

Another danger to be avoided is the counselor's being perceived as showing preference to some clients. It is important that the counselor be equally supportive of all group members and not allow them to engage in competition for attention.

The counselor can find discussions of group development, leadership, concepts, techniques, and other helpful information for conducting group therapy in Treatment Improvement Protocol 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005*b*), a free publication from the Center for Substance Abuse Treatment.

Appendix C.
Sample Agreement for Co-Leaders and Client–Facilitators

All clients serving as group co-leaders or client–facilitators are required to read and agree to abide by the conditions below, as indicated by initialing each item and signing at the bottom of the form.

As a co-leader or client–facilitator I agree to the following:

_____ To commit to participating in ____ group sessions per week for at least 3 months (for co-leaders) or 6 months (for client–facilitators).

_____ To participate in regular pregroup and postgroup meetings with my assigned group counselor.

_____ To be on time for scheduled groups. If I am unable to attend a scheduled group, I will call and notify the program 24 hours in advance.

_____ To abstain from using illicit drugs or alcohol and from abusing prescription drugs.

_____ To respect and maintain client confidentiality with respect to information disclosed in group sessions.

_____ Not to become involved socially, sexually, or economically with group members or with other program clients.

_____ To abide by the program's statement of ethical conduct.

_____ That I am entering this agreement on a strictly volunteer basis; I understand that I will not be paid for my time.

_____ To actively participate in some form of ongoing recovery support or treatment.

_____ That any departure from the above conditions could result in my termination from the co-leader or client–facilitator position.

_____ _____
Co-Leader's Signature Date

_____ _____
Client–Facilitator's Signature Date

_____ _____
Counselor's Signature Date

_____ _____
Program Director's Signature Date

Appendix D.
Acronyms and Abbreviations List

AA	Alcoholics Anonymous
ACoA	Adult Children of Alcoholics
Al-Anon	A support group for families and loved ones of people who are addicted to alcohol
Alateen	A support group for young family members and loved ones of people who are addicted to alcohol
ASI	Addiction Severity Index
CA	Cocaine Anonymous
CAL	Calendar (for worksheets used during scheduling)
CMA	Crystal Meth Anonymous
CoDA	Co-Dependents Anonymous
CSAT	Center for Substance Abuse Treatment
EA	Emotions Anonymous
ERS	Early Recovery Skills
GA	Gamblers Anonymous
HALT	Hungry Angry Lonely Tired
IC	Individual/Conjoint
IOP	Intensive Outpatient Treatment for People With Stimulant Use Disorders
JACS	Jewish Alcoholics, Chemically Dependent Persons and Significant Others
MA	Marijuana Anonymous
meth	Methamphetamine
MTP	Methamphetamine Treatment Project
NA	Narcotics Anonymous
Nar-Anon	A support group for families and loved ones of people who are addicted to narcotics
OA	Overeaters Anonymous
PA	Pills Anonymous
RP	Relapse Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
SCH	Schedule (for worksheets used during scheduling)
SMART	Self-Management and Recovery Training
SS	Social Support
TAU	Treatment as Usual

Appendix E. Further Reading

The articles listed below provide more information about treatment for methamphetamine dependence in general and the Matrix model in particular.

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